Northwest Physicians Associates, P.C., its subsidiaries and d/b/a (s)
1012 Water Street, Meadville, PA 16335 (814) 333-2001

FORM MRR-1 Physician Initials_____

Authorization for the Release of the Medical Record/PHI

_____	_____-_____-_____	_____
Patient Name	Social Security Number	Date of Birth

1. I hereby authorize_____ to release my medical records as indicated below, to:
Physician's Name (Please Print)

_____
Name of Physician or Facility

_____
Address

_____
City, State, Zip Code

Each Item You Would Like To Be Released MUST Be Initialed

_____ **Initial Examination**
_____ **Follow-up/Progress Notes**
_____ **Special Procedure Results**
_____ **Discharge Summary**
_____ **Office Visit Notes**
_____ **Pathology Reports**
_____ **Other:**_____

PURPOSE FOR THIS REQUEST: ☐ Transfer of care to another physician ☐ Personal ☐ Legal ☐ Second Opinion ☐ Other_____

The copy of the medical record will be mailed to the address indicated above unless otherwise instructed. If the record is going to be picked up and the person receiving the record is NOT the patient or legal guardian, please indicate who you authorize to do so.

_____ _____
Authorized Person (Please Print) Birth Date of Authorized Person

*This authorization will expire thirty (30) days from the date of my signature or as otherwise specified by date, event or condition as follows:_____

I UNDERSTAND:

1. That I may revoke this authorization, by notifying the physicians office of such, at any time, except to the extent that action has been taken in reliance on it and that in any event this authorization expires automatically as described above.
2. That information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.
3. The following information is further protected by law. It will not be released unless you complete a separate medical release designed for this purpose.
   -AIDS and HIV Records
   -Alcohol and Drug Abuse Records
   -Psychotherapy Notes
   -In-patient Mental Health Records
   -Involuntary Outpatient Mental Health Records

SIGNATURE: Refusal to sign this authorization will not affect your ability to obtain treatment by Northwest Physicians Associates except in the case of healthcare that is solely for the purpose of creating healthcare information for disclosure of a third party.

_____ _____
Signature of Patient or Personal Representative Date

_____ _____
If Personal Representative, Name Printed If Personal Representative, Describe Authority

_____ _____
Witness/Notary Signature Witness/Notary, Name Printed

- **A notary seal is required if the release is mailed or faxed to NPA and the medical record is being sent to any other address other than the physician office.**
- **A photo ID is required if the release is not witnessed by an employee of the physician office that is to receive the medical record.**
- **Note to our employees: When an authorization is completed in the office, if you are not familiar with the individual, you are required to verify identity through a photo ID and attach a copy of the ID to the release.**